



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

LIFECARE HOSPITALS OF SHREVEPORT  
P O BOX 971805  
DALLAS TX 75397

#### **Carrier's Austin Representative Box**

Box Number 19

#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **MFDR Date Received**

December 19, 2011

#### **MFDR Tracking Number**

M4-12-1214-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Lifecare is considered a Long term Acute Care Facility and should be at least paid at a fair and reasonable rate of at least 100% of the LTCH – DRG Medicare allowable."

**Amount in Dispute:** \$32,368.56

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The carrier maintains that the provisions of the Coventry-First Health contract prevail over what amount may have been reimbursed under the Medicare Provisions. Furthermore, it does not appear that Medical Dispute Resolution was requested in a timely manner."

**Response Submitted by:** Chartis, 4100 Alpha Road, Suite 700, Dallas, TX 75244

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2010 To September 24, 2010	Inpatient Hospital Surgical Services	\$32,368.56	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 13, 2011

- Paid according to state fee schedule guidelines and your contract with First Health

Explanation of benefits dated September 8, 2011

- 1 – (45) Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 1 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business. (P303)

- 2 – (W1) Workers Compensation State Fee Schedule Adjustment.
- 2 – This bill was reviewed in accordance with a Coventry-First Health owned contract. For questions regarding this analysis, please call 1-800-937-6824 (Z547)
- 3 – The charge for this procedure exceeds the fee schedule allowance. (Z710)

### Issue

1. Did the requestor waive the right to medical fee dispute resolution?

### Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute listed on the requestors *Table of Disputed Services* shows September 1, 2010 through September 24, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 19, 2011. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

### Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

### Authorized Signature

		July 27, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		July 27, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**